Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DR PETER E GRAYS
1909 CENTRAL DRIVE #202
BEDFORD TX 76021

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name
EMPLOYERS INSURANCE CO OF WAUSAU

Carrier's Austin Representative Box
Box Number 01

MFDR Tracking Number
M4-12-2046-01

MFDR Date Received
FEBRUARY 7, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as stated on the Table of Disputed Services: "Patient had Bilateral Incarcerated Inguinal Hernias Repaired. Seperate [sic] indicated procedure."

Amount in Dispute: $2,281.24

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The respondent did not submit a response to the request for medical fee dispute resolution."

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 15, 2011	CPT Codes 49507-59-RT, 55520-59-RT, 49507-59-LT and 55520-59-LT	$2,281.24	$1,435.87

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.203 sets out the reimbursement guidelines for professional services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits:
   - 17, U899 – Procedure has exceeded the maximum allowed units of service.
   - W1, U899 – Procedure has exceeded the maximum allowed units of service.
   - B15, U008 – This separate independent procedure is considered an integral part of the total services performed and does not warrant a separate charge.
   - 16, X628 – This charge was billed in error.

Issues

1. Where the codes billed eligible for reimbursement?
2. Is the requestor entitled to reimbursement?

Findings

1. The requestor billed two units of CPT Code 49507; the insurance carrier issued payment for one unit and denied the second unit using reason codes 16, X628 – "This charge was billed in error" and 17, U899 – "Procedure has exceeded the maximum allowed units of service."

   The requestor billed two units of CPT Code 55520; the insurance carrier denied both units using reason code B15, U008 – This separate independent procedure is considered an integral part of the total services performed and does not warrant a separate charge.

   In accordance with 28 Texas Administrative Code §134.203(b) for coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules.

   - Medicare rules for CPT Code 49507 allows for a bilateral procedure with a multiple surgery reduction.
   - Medicare rules for CPT Code 55520 (two units) allows for a bilateral procedure with a multiple surgery reduction and allows an appended modifier -59.

   The above denial reasons are not supported. Therefore the disputed services will be reviewed for payment in accordance with applicable Division rules and fee guidelines.
2. Review of the submitted operative report supports the treatment was rendered as billed. Therefore; in accordance with 28 Texas Administrative Code §134.203(c) states in pertinent part, "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.(1) … For surgery when performed in a facility setting, the established conversion factor to be applied is $66.32…(2) Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year." The MAR for the payable services may be calculated by (2011 TDI-DWC Surgery Conversion Factor / MEDICARE CONVERSION FACTOR) x Facility Price = MAR

   CPT Code 49507-59-RT – (68.47÷34.023) x $559.46 = $1125.90 x application of multiple procedure discount of 50% = $562.95

   CPT Code 55520-59-LT – (68.47÷34.023) x $433.76 = $872.92 x application of multiple procedure discount of 50% = $436.46

   CPT Code 64721-59-RT – (68.47÷34.023) x $$433.76 = $872.92 x application of multiple procedure discount of 50% = $436.46

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $1,435.87.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $1,435.87 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

		April 4, 2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.